TARGETED CASE MANAGEMENT (301)

P - (Purpose): Targeted case management services to help with housing and medical care

I - (Intervention): Helped Janine organize information regarding her stay at Mary Isaak Center, and determine if she needed to do anything regarding her financial or community-service responsibilities. Helped Janine phone Petaluma Health Center to schedule neuropsych testing. Offered to help schedule a neurosurgery follow-up at UCSF, but Janine said she would follow up on that. Helped Janine identify needed next steps to update her EBT and Medi-Cal cards with her current legal name. Encouraged Janine to continue working with her COTS case manager on any issues she was having at MIC.

R - (Response): Janine said that her COTS stay has been extended for 30 days, and that COTS has said that they can "work with her" to provide support if she has her knee-replacement surgery. Janine vented at length about the other people at the shelter, but she said that she has made friends there. She also said she is "getting more vocal" and speaking up when there are problems, as well as doing community service. She said she will also start attending CODA meetings, saying, "Someone told me it was for weenies who can't say 'no.'" Janine was oriented and engaged but struggled to make decisions and seemed easily distracted.

PL - (Plan): Janine said she will follow up with UCSF for neurosurgery follow-up. Her neuropsych testing appointment is scheduled for 7/28. Janine agreed to attend next DBT Skills Group.

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COORDINATION WITH EXISTING CONTRACTED PROVIDER/CBO

P - (Purpose): Targeted case management services to coordinate with Matthew's therapist
I - (Intervention): Contacted Matthew's therapist Jane Smith to discuss whether Matthew was benefitting from or attending therapy, given family's recent lapse in Medi-Cal and his recent no-show for his psychiatric appointment.
R - (Response): Jane said that Matthew attends therapy regularly and seems to be benefitting from the service. She also said that she can continue to provide services during the Medi-Cal lapse.
PL - (Plan): Jane will follow up with Matthew's family and refer them to a Medi-Cal eligibility worker. She will also encourage Matthew's mother to reschedule his missed YFS appointment.

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TARGETED CASE MANAGEMENT (301) – REFERRALS & STEP-DOWNS

NEW REFERRAL TO CONTRACTED PROVIDER/CBO

P - (Purpose): Targeted case management services to link Aisha to Lifeworks for family therapy
I - (Intervention): Spoke with Aisha's mother to provide information about Lifeworks and their services. Using clinical knowledge of client, completed referral packet, including current diagnoses, psychosocial history and current factors, and treatment goals. [Photocopying/clerical tasks not included in time claimed.]
R - (Response): Aisha's mother agreed with Lifeworks referral.
PL - (Plan): Clinician will send the referral packet to Lifeworks and follow up as needed.

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LINKAGE REFERRAL FORM FOR TEAM TRANSFER/CONTRACTOR

P - (Purpose): Targeted case management services to refer Carlos to a team for treatment of Schizophrenia
I - (Intervention): Using clinical knowledge of client, completed referral packet, including detailing his service needs, current providers, living situation, and pertinent psychosocial history. [Photocopying/clerical tasks not included in time claimed.]
R - (Response): Referral packet completed.
PL - (Plan): Clinician will send the referral packet to next Linkage meeting and follow up as needed.

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COMPLETING BENEFICIARY REQUEST FOR SERVICE

P - (Purpose): Targeted case management services to link Stefan to eating-disorder services
I - (Intervention): Spoke with Stefan and his family to provide information about therapists specializing in eating-disorder treatment in the community and the process for requesting those services. Consulted with Dr. Iversen regarding treatment request. Using information gathered from family discussion and psychiatric consultation, as well as clinical knowledge of client, completed Beneficiary Request for Service, including current impairments, treatment team's recommendation, and clinical urgency of request.
R - (Response): Stefan is ambivalent but willing to pursue eating-disorder treatment, and his family very much wants these services. Dr. Iversen reported that she is concerned about Stefan's physical health and would like him to begin eating-disorder treatment quickly.
PL - (Plan): Clinician will submit completed BRS form to program manager for review and approval.

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STEP DOWN OF CLIENT NOT MEETING ASSESSMENT CRITERIA FOR SMHS

P - (Purpose): Targeted case management services to link Barnaby with the appropriate level of care for treatment of Adjustment Disorder
I - (Intervention): Completed Beacon bi-directional form, including Barnaby's current treatment goals and diagnosis. Faxed completed form to Beacon [not included in claimed time]. Called Sonoma 4Cs and confirmed Barnaby's enrollment in their program.
R - (Response): N/A
PL - (Plan): After ensuring that transition is complete, clinician will close Barnaby to SCBH services.

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STEP DOWN OF CLIENT WHOSE SYMPTOMS & IMPAIRMENTS HAVE RESOLVED

P - (Purpose): Targeted case management services to link Marianna with the appropriate level of care for treatment of Major Depressive Disorder
I - (Intervention): Completed Beacon bi-directional form, including Marianna's current treatment goals and diagnosis. Faxed completed form to Beacon [not included in claimed time]. Called Sonoma 4Cs and confirmed Marianna's enrollment in their program.
R - (Response): N/A
PL - (Plan): After ensuring that transition is complete, clinician will close Marianna to SCBH services.

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WRITING DISCHARGE SUMMARY (INCLUDING MDs)

P - (Purpose): To link Benny with PCP to assure continuity of care for treatment of Schizophrenia.
I - (Intervention): Reviewed Benny's records. Based on chart review and clinical knowledge of client, wrote summary for client's PCP of treatment history, current challenges, strengths, and laboratory findings to assist PCP with continuity of care as client steps down management of their psychiatric condition to their primary care provider.
R - (Response): [Brief overview of treatment history and challenges. Can copy and paste from summary.]
PL - (Plan): Benny's PSC will complete process of transferring client's care to PCP.